STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445234	A. BUILDING _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN OAKS HEALTH AND REHABILITATION	1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160

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F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to honor choices for 1 of 39 (Resident #165) sampled residents for bathing preferences. The findings included: Resident #165 was admitted to the facility on 6/12/15 with diagnoses that included pneumonia, diabetes, difficulty walking, muscle weakness, symbolic dysfunction, cellulitis and abscess of leg, hypertension chronic pain, depression, peripheral neuropathy and anxiety. The admission Minimum Data Set (MDS) dated 6/19/15 recorded the resident's Brief Interview for Mental Status (BIMS) score was 13, which indicated intact cognition. The MDS recorded the resident did not have any behaviors, and did not refuse care and was totally dependent on staff for bathing. Review of the Progress Notes from 6/12/15 through (-) 6/25/15 lacked evidence that staff offered a shower to the resident and the resident refused. acceptable POC 7/23/15 sp	F 242	This Plan of Correction affirms our allegation of compliance for the deficiencies cited, however submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction has been respectfully developed and submitted as required for compliance with federal and state regulations. **F242-Right to make choices.** 1)Resident #165 was interviewed by the DON 6/25/15 to confirm her choice of shower/shower days. The DON reviewed the shower schedule which is maintained at the nursing station on 6/25/15 to ensure the residents' choice is being honored. 2) Any resident is at risk for the identified deficient practice. Current residents or family were interviewed 7/17/15 by the ADON, RN supervisor, RN Unit Manager & the SDC for their choice of a shower or bath and the days for their scheduling choice. Those residents requesting a change in their schedule or preference for a bath versus a shower were noted with a change in the shower schedule located on each nursing station was completed 7/21/15. The care plans & NA's POC for those residents' with an expressed preference for a full bed bath were updated by the DON 7/21/15.	7/24/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/23/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This same POC was faxed 7/23/15 sp

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F 242	Continued From page 1 During interview with Resident #165 on 6/22/15 at 2:35 P.M., Resident #165 stated it was "very important" to him/her to choose between a tub bath, shower, bed bath, or sponge bath. During interview with the resident's friend/family on 6/22/15 at 2:35 P.M., he/she stated the resident complained about the lack of showers he/she received, and wanted more. During interview on 6/25/15 at 11:53 A.M., Licensed Nurse (LN) BB stated the resident was given showers 3 times since admission on 6/12/15, on June 17, 20, and 24/15. LN BB stated staff was expected to offer 3 showers per week, and document if the resident refused. LN BB acknowledged staff did not document the resident refused showers. The staff did not offer the resident enough showers or find out if he/she wanted a bed bath. On 6/25/15 1:18 P.M., LN BB stated the facility did not have a policy for showers/bathing but the standard and the practice of the facility was to offer showers 3 times per week. On 6/25/15 at 1:53 P.M., LN GG stated staff did not offer enough showers/bathing to the resident. The facility failed to offer Resident #165 showers as desired.	F 242	**F242 Continued** 3) Licensed Nurses and Certified Nursing Assistants were re- educated by the DON which was completed 7/22/15 regarding the facility Bathing/Shower Standards and the residents or family choice of a shower or bath. Resident shower/bath schedules were implemented by 7/22/15 with the resident or family choice indicated on the shower schedule. The DON provided a copy of the Bathing/Shower standard to the licensed and certified staff by 7/22/15. 4) The DON or designee will conduct an audit of the shower/bath schedule(s) weekly x 4 weeks, then bi-monthly x 4 weeks, then monthly x 1 month to ensure residents are offered a shower/bath per facility standards & per their preferred means of bathing. Residents will be re-interviewed by the DON or designee within the next 30 days to ensure the residents' Bathing/Shower preference is being honored and they are satisfied with the current schedule. The DON/designee present the results of the audits to the QAPI committee which consists of the Medical Director, Administrator, DON, ADON, Social Services, Activities, Dietary Manager &/or Registered Dietician, Plant Manager and RFC on at least a quarterly basis. Any aberrancies will be discussed and reviewed by the committee for interventions.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		

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F 250	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review, review of a job description, and interview, the facility failed to ensure the social service staff initiated and participated in meeting the psychosocial needs of 1 of 39 (Resident #23) sampled residents. The findings included: Resident #23 was admitted to the facility on 4/3/15 with a diagnosis of dementia, adult antisocial behavior, anxiety and altered mental status. The resident uses psychotropic medication of Ativan and Trazodone related to the disease process insomnia. A review of the Minimum Data Set (MDS) dated 4/10/15 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 2, indicating the resident was severely impaired. Resident #23 was readmitted to the facility on 5/26/15 at 5:30 P.M. after a hospital stay for multiple diagnosis including altered mental status, dementia and urinary tract infection. There was no documented possible psychosocial needs as the resident's plan of care note (5/26/15 at 7:18 P.M.) revealed the resident had a Peripheral Inserted Central Catheter (PICC) line in left upper arm with a lot bruising around site. Review of the medical record on 6/24/15 revealed there was no assessment by the social worker at admission for Resident #23 nor any documented interventions for behaviors documented in the resident's progress notes, first noted on 4/9/15	F 250	F250 1) Resident #23 has a social history admission assessment completed by the social worker on 7/16/15. Behavioral interventions were in place in resident #23's care plan prior to 7/16/15. 2) Any resident is at risk by the identified deficient practice. Current residents have been reviewed and have a social history admission assessment in place by the Social Services Director on 7/23/15 and are up to date. 3) The Social Services Director was re-educated on accurate and timely completion of the social history admission assessments by the Administrator on 7/16/15. 4) Director of Social Services, Nursing, Administrator or designee will audit three per week for four weeks, then weekly for two months for social history admission assessments being completed. Any concerns will be addressed for correction at Quality Assurance and Performance Improvement meeting.	7/24/15

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F 250	Continued From page 3 with continuous, almost daily, episodes of anxiety which require administration of Ativan. Review of the social worker's signed job description noted that the job duties and responsibilities of the Social Worker was to "perform assessment of the resident at admission, upon change of condition and/or annually; create, review and update care plan and progress notes". In addition the duties include to "provide direct psychosocial intervention." During an interview on 6/25/15 at 4:13 P.M., the Director of Social Work (LL) revealed she was not able to do an assessment as the form did not populate in Point Click Care (PCC). The social services director has been employed in the facility since 5/19/14 and had failed to do initial assessments for resident to ensure that their psychosocial needs are being met. She stated that she did keep notes on the residents but there was no documentation in the medical record to ensure that the needs of this resident were being addressed. Further interview with the Director of Social Work (LL) revealed at the time of Resident #23's care plan meeting shortly after admission, she was out of the building taking another resident to an appointment. Therefore she was not included at that time in the interdisciplinary team decisions including providing direct psychosocial interventions.	F 250		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272		

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F 272	Continued From page 4 A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of a job description, policy review, and staff interview, the facility failed to ensure 2 of 39 (Residents #23	F 272	F272 1)Resident #84 has an admission Nutrition Assessment in place as of 2/16/15 by the Registered Dietician. Resident #23 has a social history admission assessment in place on 7/16/15 completed by the Social Services Director. Behavioral interventions were in place in resident #23's care plan prior to 7/16/15. 2) Any resident is at risk by the identified deficient practice. Current residents have been reviewed by the Dietary Manager on 7/22/15 and have an admission Nutritional Assessment in place. Current residents have been reviewed by the Social Services Director on 7/23/15 and have a social history admission assessment in place. 3) The Social Services Director was re-educated on accurate and timely completion of the social history admission assessment by the administrator on 7/16/15. The Registered Dietician was re-educated on completing the admission Nutritional Assessment by the administrator on 7/16/15. 4) Director of Nursing, Social Services Director, Administrator or designee will audit three per week for four weeks, then monthly for two months to ensure the social history admission assessments and admission nutrition assessments are being completed accurately and timely. Any concerns will be addressed for correction at Quality Assurance and Performance Improvement meeting.	7/24/15

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F 272	Continued From page 5 and #84) sampled residents were assessed for psychosocial and nutritional needs. The findings included: 1. Resident #23 was admitted on 4/3/15 with diagnosis of dementia, adult antisocial behavior, anxiety and altered mental status. The resident used psychotropic medication of Ativan and Trazodone related to the disease process insomnia. Nursing progress notes revealed the following: a. 4/9/15 - 16:12 - Note Text: Ativan Tablet 0.5 milligram (mg) Give 1 tablet by mouth as needed for anxiety/agitation related to anxiety disorder conditions classified elsewhere. Give one tablet by mouth (po) twice a day (BID) as needed (PRN) anxiety/agitation severe agitation. b. 4/9/15 - 18:17 - Note Text: yelling screaming most of evening, family was upset yesterday for resident receiving Ativan and resident was sleeping. Contacted family member (power of attorney) and they said to give Ativan. c. 4/10/15 - 19:19 - Note Text: Trazodone HCl Tablet Give 25 mg by mouth as needed for insomnia give 25 mg by mouth at bedtime (HS) PRN one hour after melatonin administration, If melatonin is ineffective. d. 4/11/15 - 22:10 - Note Text: resident has increased anxiety at HS has melatonin 3 mg scheduled at HS, but is not very effective in assisting resident to calm down. Have to give him his prn Trazodone and Ativan for him to calm down. Message left in doctor's book, will continue to monitor. e. 4/13/15 - 14:33 - Note Text: resident was quiet first part of day but family visited during this time, now yelling and screaming being - very disruptive	F 272		

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F 272	Continued From page 6 to others and spouse that is also a resident. f. 4/13/15 - 16:47 - PRN Administration was: Ineffective - resident still yelling, wanting spouse to get out of bed and rub resident's shoulders. g. 4/15/15 - 11:20 - Medication Administration Note Text: Ativan Tablet 1 mg Give 1 tablet by mouth as needed for agitation related to anxiety disorder conditions classified elsewhere BID. h. 4/15/15 - 19:30 - Medication Administration Note - Ativan given again. i. 4/17/15 - 11:55 - Medication Administration Note Text: Ativan Tablet 1 mg Give 1 tablet by mouth as needed for agitation related to anxiety disorder conditions classified elsewhere BID PRN Administration was: Effective - Some calmer not yelling out, resident is singing. j. 4/17/15 - 18:02 - Behavior Note / anxiety Note Text: resident yells and screams for spouse or yelling lets go, Ativan had poor effect. k. 4/21/15 - 16:26 - Medication Administration Note Text: Hydrocodone-Acetaminophen Tablet 5-325 mg Give 1 tablet by mouth every 6 hours as needed for pain Give one tablet by mouth every 6 hours PRN pain. Hold for sedation Review of the medical record on 6/24/15 revealed there was no assessment by the social worker at admission nor any documented interventions for behaviors noted in the resident's progress notes. Review of the social worker's signed job description noted that the job duties and responsibilities of the Social Worker was to "perform assessment of the resident at admission, upon change of condition and/or annually; create, review and update care plan and progress notes". In addition the duties include to "provide direct psychosocial intervention."	F 272		

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F 272	Continued From page 7 During an interview with the Director of Social Work (LL) on 6/24/15 at 4:13 PM, revealed she was not able to do an assessment as the form does not populate in Point Click Care. The social services director has been employed in the facility since 5/19/14 and had failed to do initial assessments on admission and upon change of condition for Resident #23 to ensure their psychosocial needs are being met. In addition there was no documentation in the progress notes of direct psychosocial interventions as per the Social Worker's job description. 2. Review of Resident #84's medical record on 6/25/15 at 9:30 A.M., revealed the resident was admitted on 12/17/14 with diagnosis which included malignant neoplasm other specific site, edema, hypertension, depressive disorder, noninfectious lymphedema, and hypothyroidism. The medical record revealed an admission nutrition assessment was completed on 2/6/15 which was 50 days after his/her admission into the facility. Review of the facility's Registered Dietitian Duties (Policy) revealed the dietitian was to chart on all new admissions within 72 hours / 24 hours for resident with tube feedings or complex nutritional needs. During an interview with the Director of Nursing (BB) on 6/25/15 at 11:35 A.M., revealed he/she admitted the previous dietitian had been behind on completing some of the nutritional assessments. During an interview with the Registered Dietitian	F 272		

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F 272	Continued From page 8 (KK) on 6/25/15 at 11:40 A.M. via telephone revealed he/she started working in the facility on 12/22/14. The dietitian indicated the facility's policy for completing nutritional assessments upon admission was for the dietitian to have them completed within 14 days of admission. When asked how he/she obtains the information on what resident's he/she needs to assess, the dietitian reported the Director of Nursing informs him/her of that information.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, observation, interview,	F 279	**F279-Development of Comprehensive Care Plans** 1)Resident #161 care plan was reviewed by the DON 6/24/15 for accuracy and to ensure interventions were in place for accident prevention. Interventions were appropriate with no revisions necessary at the time of review. Resident # 133 & resident # 60 were closed/discharged records. 2) Any resident admitted to the facility is at risk for the identified deficient practice. An audit was performed by the DON 7/21/15 to ensure an interim care plan is in place and reflective of the residents status for those residents admitted/re-admitted to the facility within the past 30 days with any revisions (if needed) completed by 7/22/15.	7/24/15

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F 279	Continued From page 9 review of an incident report and policy review, the facility failed to develop a comprehensive or interim care plan for 3 of 39 (Residents #161, #133 and #60) sampled residents. The findings included: 1. Resident #161 was admitted to the facility on 6/12/15 with diagnoses that included coronary atherosclerosis of artery bypass graft, difficulty in walking, general muscle weakness, diabetes, congestive heart failure, hypertension, chronic ischemic heart disease, arthropathy, esophageal reflux, glaucoma, morbid obesity, depressive disorder, restless legs syndrome, and anxiety. Review of the admission nursing assessment recorded on 6/12/15 at 6:22 P.M., revealed staff assessed the resident post open heart surgery, a double coronary bypass on 6/4/15. Staff recorded on the safety assessment the resident's medications were non - steroidal anti - inflammatories (NSAIDS), diuretics, hypoglycemics, antihypertensives, narcotics and benzodiazepines. Staff assessed the resident's current Activities of Daily Living (ADL) status as needing extensive assistance for dressing and personal hygiene, bed mobility, transfers and toilet use. Gait analysis recorded the resident was unable to independently come to a standing position. The medical record lacked evidence of an initial or interim care plan. The Certified Nursing Assistant (CNA) Kiosk listed no interventions for this resident upon admission.	F 279	**F279 Continued** 3) The DON re-educated Licensed Nurses 7/17 to 7/22/15 on the facility standards for the development of an interim care plan by the licensed nurse, review/validation within 24 hours of admission by the unit manager or designee for completion, accuracy and subsequent interventions. The development of the care plan will include interventions in the POC Kiosk to provide NA staff the information necessary to provide care to the resident following admission. MDS nurses were re-educated 7/22/15 by the DON to ensure resident care plans reflect of the residents' current status with CAA notes & MDS triggered care areas appropriately reflected/incorporated in the resident care plan. 4) The DON/designee will audit interim care plans for new admission weekly x 4 weeks, then bi-monthly x 4 weeks, then monthly x1 month to validate the care plan is in place and reflects the current resident care needs and interventions. The DON/designee presents the results of the audit(s) to the QAPI Committee on at least a quarterly basis. Any aberrancies are discussed and reviewed by the committee for interventions.	

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F 279	Continued From page 10 Observation of Resident #161 on 6/24/15 at 8:22 A.M., revealed the resident sat in a chair in his/her room with a hematoma on the right forehead and around the right eye (black eye). During an interview with the resident and a family member on 6/24/15 at 8:22 A.M., the resident and family member stated the resident was admitted on Friday, 6/12/15, and fell on Sunday, 6/14/15 at about 3:00 A.M. The resident stated he/she got up to go to bathroom, fell face first and got the black eye. The resident stated, "I don't feel the same as before my fall; I'm more confused." Review of the Incident Report, dated 6/14/15 at 3:30 A.M., recorded the resident was found on the floor of the bathroom lying face down on the floor in his/her own urine with no footwear present. The report noted the resident's statement was he/she woke up and forgot where he/she was, wandered into the bathroom and fell face first. The report noted a right forehead hematoma, however the report lacked evidence of a complete physical assessment after a fall with a head injury. On 6/17/15, when the care plan was finally developed (3 days after the resident's fall with injury), the care plan lacked any information or interventions for the black eye. On 6/24/15 at 11:47 A.M., CNA HH stated he/she cared for the resident on Saturday, 6/13/15, and the resident was not in the Kiosk yet, where they usually get the care information. During an interview on 6/24/15 at 11:24 A.M., Licensed Nurse (LN) GG stated at admission the nurse completed the Initial Nursing Assessment,	F 279		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN OAKS HEALTH AND REHABILITATION	1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 11	F 279		

then the RN supervisor or Unit Manager should have initiated a care plan based on the assessment. LN GG stated the resident "was missed", and no care plan was initiated for the resident. LN GG stated, "The resident's care plan was not in place until the 17th; there isn't anything in the whole care plan until the 17th." LN GG stated the care plan should have been completed and the care information sent to the CNA kiosk.

During an interview on 6/24/15 at 2:09 P.M., LN BB stated with no care plan in place, he/she did not know how CNA staff knew how to care for and assist a new resident. LN BB stated the expectation was that licensed staff would initiate an Interim Care Plan when a new resident was admitted, with some basic information on it for care of the resident, ideally within 24 hours of admission. LN BB stated the facility had 5 admissions at the same time, and it took more than 5 hours just to input orders. LN BB admitted the resident did not have an Interim Care Plan, and acknowledged the care plan was not developed until 6/17/15.

During an interview on 6/24/15 at 3:54 P.M., LN BB stated, "I don't know where [the resident] got the black eye; not documented." LN BB admitted there was not a care plan or interventions for the black eye sustained on 6/14/15, and the injury wasn't listed on the care plan developed 6/17/15.

On 6/25/15 at 4:00 P.M., LN BB provided the policy entitled Interim Care Plans, undated, which directed: "1. Upon admission of a resident the admitting nurse will evaluate the resident's condition and develop an Interim Care Plan. 2. Within 24 hours, the Registered Nurse (RN) Unit Manager will validate the accuracy of the Interim

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F 279	Continued From page 12 Care Plan and add any further identified concerns/interventions and communicate to staff for implementation. Interim Care Plans are reviewed by Interdisciplinary Team (IDT) to ensure resident care and safety (Morning Meeting, At Risk Meeting...). 3. New Admissions are to have an Interim Care Plan in place until Comprehensive Care Plans are developed and implemented." The facility failed to provide a comprehensive care plan for this resident or interventions to prevent accidents. 2. Review of the closed medical record revealed Resident #133 was admitted to the facility on 12/30/14 with a diagnosis of urinary tract infection. The resident's care plan dated 12/31/14 did not identify a problem with bladder incontinence or provide any interventions to address incontinence. Review of the nursing admission assessment dated 12/31/14 revealed the resident was listed as incontinent of bladder. The admission Minimum Data Set Assessment (MDS) dated 1/6/15 had the resident coded as frequently incontinent. The 14 day MDS Assessment dated 1/11/15 had the resident coded as always incontinent. The first bowel/bladder assessment after admission was completed on 3/30/15 which the resident indicated her incontinence had been going on for 1 to (-) 2 years. During an interview the MDS Coordinator (Nurse JJ) reviewed the closed medical record for Resident #133 on 6/24/15 at 3:33 P.M. and	F 279		

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F 279	Continued From page 13 revealed the admission assessment and the 30 day assessment had the resident coded as frequently incontinent, and the quarterly assessment dated 4/2/15 had her coded as always incontinent. After further review of the record she was unable to find any care plan for incontinence during the resident's stay in the facility. During an interview on 6/24/15 at 3:33 P.M., the MDS Coordinator was asked about a care plan for incontinence for Resident #133. The MDS Coordinator stated "Oh, that was missed." 3. Resident #60 was readmitted on 3/23/15 with a diagnosis of atherosclerosis unspecified bypass graft extremities and muscle weakness; and was discharged 4/29/15 to the hospital. Review of discharge records revealed the 2/25/15 quarterly Minimum Data Set (MDS) reported Resident #60 Brief Interview for Mental Status (BIMS) score was 8, indicating cognition impairment. Review of the record revealed 3/23/15 Resident #60 Evaluation Readmission Assessment under Section "O" of the Vision/Hearing tab noted Resident #60 had visual impairment and arrived at the facility with glasses. Review of the MDS revealed the 3/30/15 - 5 day assessment reported Resident #60 was visually impaired, and had eye glasses in the facility, could see adequately with them, and required staff to remind him to wear them to prevent risk. On 4/6/15 the MDS reported Resident #60 had vision impairment and had corrective lenses. On 4/24/15 a review of his 30 day assessment revealed Resident #60 was reported with impaired vision and no eye glasses. Review of	F 279		

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F 279	Continued From page 14 Resident #60 discharge records revealed there was no inventory list or documentation of personal items Resident #60 discharged with. The facility was inconsistency with Resident #60's assessment as to whether he had eye glasses at the facility. Review of Resident #60's care plan revealed there was no problem or interventions for vision impaired requiring glasses. During an interview on 6/24/15 at 3:12 P.M., with the Director of Social Work revealed Resident #60 was admitted to facility with eye glasses and concurred Resident #60 visual impairment and glasses was no on the care plan. During an interview on 6/25/15 at 9:42 A.M., with the Unit Manager GG confirmed Resident #60 care plan was not updated to reflect vision impairment and interventions. During an interview on 6/25/15 at 10:28 A.M., with the MDS Coordinator JJ revealed she confirmed the care plan under the MDS Care Area Assessment (CAA) was not completed and Resident #60 vision impairment and staff interventions were not created on the care plan. During an interview on 6/25/15 at 11:01 A.M., with the Director of Nursing BB confirmed the care plan under the MDS Care Area Assessment (CAA) was not completed and Resident #60 vision impairment and staff interventions were not created on the care plan. BB revealed her expectations was that the CAA be completed and the problems identified along with the intervention be created and added to the care plan.	F 279		

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F 281 F 281 SS=D	Continued From page 15 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation, interview, review of Centers for Disease Control (CDC) statistical article entitled Injury Prevention and Control: Traumatic Brain Injury (TBI), and policy review, the facility failed to provide professional services and monitoring a fall for 1 of 39 (Resident #161) sampled residents. The findings included: Resident #161 was admitted to the facility on 6/12/15 with diagnoses that included coronary atherosclerosis of artery bypass graft, difficulty in walking, general muscle weakness diabetes, congestive heart failure, hypertension, chronic ischemic heart disease, arthropathy, morbid obesity, esophageal reflux, glaucoma, depressive disorder, restless legs syndrome, and anxiety. Review of the admission nursing assessment recorded on 6/12/15 at 6:22 P.M., revealed staff assessed the resident post open heart surgery, a double coronary bypass on 6/4/15. Staff recorded on the safety assessment the resident's medications were non - steroidal anti - inflammatories (NSAIDS), diuretics, hypoglycemics, antihypertensives, narcotics and benzodiazepines. Staff assessed the resident's current Activities of Daily Living (ADL) status as needing extensive assistance for dressing and	F 281 F 281	**F281-Services Provided to Meet Professional Standards** 1) Resident #161 care plan was reviewed by the DON 6/24/15 for accuracy and to ensure interventions were in place for accident prevention. Interventions were appropriate with no revisions necessary at the time of review. NA POC kiosk was reviewed by the DON 6/24/15 to ensure resident interventions were up to date. No revisions were necessary at the time of review. 2) Any resident admitted is at risk for the identified deficient practice. An audit was performed by the DON 7/21/15 to ensure an interim care plan is in place and reflective of the residents status for those residents admitted/re-admitted to the facility within the past 30 days with any revisions (if needed) completed by 7/22/15. 3) The DON re-educated licensed nurses regarding the facility standards in the development of an interim care plan and review within 24 hours of admission, fall/ post fall assessment standards (including neuro checks), head injury standard of care, the professional notification/communication to the MD regarding resident change in status, new admit at risk 72hour monitoring standard, completion of a change in status/SBar assessment which was completed 7/22/15.	7/24/15

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F 281	Continued From page 16 personal hygiene, bed mobility, transfers and toilet use. Gait analysis recorded the resident was unable to independently come to a standing position. The medical record lacked evidence of an initial care plan for the resident. The Certified Nursing Assistant (CNA) Kiosk listed no interventions for this resident upon admission, including no safety interventions. Review of the Incident Report, dated 6/14/15 at 3:30 A.M., recorded the resident was found on the floor of the bathroom lying face down on the floor in his/her own urine with no footwear present. The report noted the resident's statement was he/she woke up and forgot where he/she was, wandered into the bathroom and fell face first. The report noted a right forehead hematoma, however the report lacked evidence of a complete physical assessment after a fall with a head injury. The Incident Report lacked evidence of a complete physical assessment of the resident after the fall. The nurses progress notes lacked any documentation whatsoever the resident had a fall with a head injury. The medical record lacked evidence of any post fall documentation for injuries. Review of the neurological examination record, dated for 72 hours, was only documented for the 24 hours. The licensed nurses failed to monitor the resident for the additional 2 days; the designated amount of time to assess neurological status.	F 281	**F281 Continued** 4) The DON/designee will audit the interim care plans for newly admitted residents and if any accident's the post fall assessment standards, professional notification/communication to the physician, and the new admit at risk 72 hour monitoring standard. The audit will also include interviews of licensed staff on how to manage new at risk residents with responses documented during the audit. The DON or designee will audit 3 x per week x 4 weeks, then weekly x 4 weeks, then monthly x 1 month. The DON/designee presents the results of the audit(s) to the QAPI Committee on at least quarterly basis. Any aberrancies are discussed and reviewed by the committee for interventions.	

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F 281	Continued From page 17 Observation of Resident #161 on 6/24/15 at 8:22 A.M., revealed the resident sat in a chair in his/her room with a hematoma on the right forehead and around the right eye (black eye). During staff interview on 6/22/15 at 4:11 P.M., Licensed Nurse (LN) MM stated the resident fell a few days after admission (6/14/15), with no injury. During an interview with the resident and a family member on 6/24/15 at 8:22 A.M., the resident and family member stated the resident was admitted on Friday, 6/12/15, and fell on Sunday, 6/14/15 at about 3:00 A.M. The resident stated he/she got up to go to bathroom, fell face first and got the black eye. The resident stated, "I don't feel the same as before my fall; I'm more confused." During interview on 6/24/15 at 10:39 A.M., LN FF stated the resident fell, hit his/her head, got a black eye, and when a resident hit their head, licensed nurses should initiate neurological (neuro) checks for 72 hours to monitor for brain injury. LN FF stated documentation after a fall should include the nurses documenting any resident changes for 72 hours. During an interview on 6/24/15 at 11:24 A.M., LN GG stated the resident "was missed", and no care plan was initiated for the resident until Wednesday, 6/17/15. LN GG stated neurological checks should be done for 72 post fall when a resident hit their head. LN GG thought the resident's neurological status, should have been monitored and documented for 72 hours after a fall, and acknowledged the neurological examination record was not complete.	F 281		

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F 281	Continued From page 18 During an interview on 6/24/15 at 11:47 A.M., CNA HH stated there was not a policy to monitor a new resident more frequently, and they did rounds every 2 hours and assisted as needed for all residents. During interview on 6/24/15 at 3:54 P.M., LN BB stated he/she expected licensed nurses to complete a physical assessment after a fall and document it in the medical record. LN BB expected licensed nurses to monitor and document a resident's fall, neurological examinations and status of injuries for 72 hours after a fall with a head injury, which was a common standard of nursing practice. LN BB agreed staff failed to complete a physical assessment record in the Fall Incident Report/Investigation. LN BB agreed staff did not record a post fall physical assessment in the Progress Notes for 72 hours. LN BB stated, "Going by the record I don't know where she got the black eye; it's not documented." Observations on 6/25/15 at 10:10 A.M., revealed LN BB, EE and FF assessed the resident. LN EE stated the resident's blood pressure was 85/50, which was low. LN EE stated the resident got lethargic after pain medications, but the resident's family member wanted the resident on more pain meds. The family member talked to the Medical Director who prescribed more. LN EE stated, "No, I did not talk to the physician about her lethargy after pain medications given. No I did not document it [lethargy]. " During an interview on 6/25/15 at 10:11 A.M., LN FF stated the resident's family requested Percocet, and wanted her to have it every 4 hours, but the order was only as needed. LN FF	F 281		

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F 281	Continued From page 19 stated, "I did not speak to the doctor about it; [the resident's] lethargy and sedation after taking medications." When asked why the lethargy was not documented in the record, LN FF had no reply, and admitted he/she documented "resident was alert" in the daily charting, but the resident was sometimes very lethargic. Observations on 6/25/15 at 10:17 A.M., revealed Resident #161 in a chair in his/her room with a glass of soda and straw. The resident was very lethargic, and unable to complete a sentence. When asked where he/she got the black eye, the resident stated, "From the shower, but I don't think it was from the insurance." Resident #161 lifted the glass, but was unable to put the straw into his/her mouth. The resident's eyes appeared glazed, and the resident periodically twitched several body parts. The Director of Nurses was alerted to the resident's condition. During an interview on 6/25/15 at 1:23 P.M., LN BB stated staff sent the resident to the hospital for evaluation. Review of the resident's medical record incident revealed no physician documentation about the resident's lethargy and confusion. During telephone interview on 6/25/15 at 1:01 P.M., the physician stated he/she did not recall if the staff from Glen Oaks reported medication side effects of lethargy and confusion, and would have to refer to the chart. The physician stated, "I have been doing this for 19 years, and have never seen a brain bleed from a head injury. I do not routinely send out [to the hospital] a resident who hits their head or face during a fall, unless they had symptoms of mental changes, speech	F 281		

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F 281	Continued From page 20 problems, hemiplegia." During an interview on 6/25/15 at 1:53 P.M., the Director of Nurses stated, the resident had a computerized tomography (CT) scan at the emergency room (6/25/15), which was negative. The resident had a urinary tract infection. Review of a CDC statistical article entitled Injury Prevention and Control: Traumatic Brain Injury, "From 2006-2010, falls were the leading cause of TBI, accounting for 40% [percent] of all TBIs in the United States that resulted in an ED [Emergency Department] visit, hospitalization, or death. Falls disproportionately affect the youngest and oldest age groups... More than two-thirds (81%) of TBIs in adults aged 65 and older are caused by falls." The facility provided the policy entitled Falls Standard, dated 11/14, which directed: All new admission will be considered "high risk for falls" and will be assessed and documented on every shift for a minimum of 3 days (72 hours). Review the Nursing Admission Assessment. Complete the Fall Risk Assessment. Review/evaluate other assessments and interdisciplinary assessments. Complete the individual resident care plan. Implement the Interim Plan of Care - Fall Risk Reduction based on individual resident needs. Communicate interventions during shift report and clinical rounds to the care teams as appropriate. Event: Head injury (document all findings and observations as directed every shift for 72 hours) *known or suspected head injury, and an unwitnessed fall. Guidance: Note any redness or swelling at potential fracture site. Displacement/rotation. Describe bruising with colors, size, and location. Pain assessment and	F 281		

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F 281	Continued From page 21 interventions to control pain. Neurological assessment: 1) Every 15 minutes x [times] 2 hours, then Every 30 minutes x 2 hours and then Every shift x 72 hours. 2) Assessment to include: Pupil response, motor function, vital signs, alertness - changes in condition, pain - description. Location, intervention if any and results; note wellness/recovery/return to normalcy. *NOTE: If assessment shows abnormal findings seek appropriate interventions and document what was done and resident response, Continue neurological checks and vital signs as indicated until normal." The facility failed to provide professional monitoring and supervision for this resident who fell 6/14/15 and sustained a hematoma.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, review of an incident report, interview, and policy review, the facility failed to develop a plan of care for accident prevention and failed to complete neurological examinations for 72 hours following a fall for 1 of 39 (Resident #161) sampled residents. Four (4) of 39 sampled residents were	F 323		

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F 323	Continued From page 22 reviewed for accidents/falls. The findings included: Resident #161 admitted to the facility on 6/12/15 with diagnoses that included coronary atherosclerosis of artery bypass graft, difficulty in walking, general muscle weakness, diabetes, congestive heart failure, hypertension, chronic ischemic heart disease, arthropathy, esophageal reflux, glaucoma, morbid obesity, depressive disorder, restless legs syndrome, and anxiety. Review of the admission nursing assessment recorded on 6/12/15 at 6:22 P.M., revealed staff assessed the resident post open heart surgery a double coronary bypass on 6/4/15. The resident ambulated into the facility. Staff recorded on the safety assessment the resident's medications were non - steroidal anti - inflammatories (NSAIDS), diuretics, hypoglycemics, antihypertensives, narcotics, and benzodiazepines. Staff assessed the resident's current Activities of Daily Living (ADL) status as needing extensive assistance for dressing and personal hygiene, bed mobility, transfers and toilet use. Gait analysis recorded the resident was unable to independently come to a standing position. The medical record lacked evidence of an initial care plan for the resident. The Certified Nursing Assistant (CNA) Kiosk listed no interventions for this resident upon admission. Review of the Incident Report, dated 6/14/15 at 3:30 A.M., recorded the resident was found on	F 323	**F323-Free of Accident Hazards/Supervision/Devices** 1) Resident #161 care plan was reviewed by the DON 6/24/15 for accuracy and to ensure interventions were in place for accident prevention. Interventions were appropriate with no revisions necessary at the time of review. NA POC kiosk was reviewed by the DON 6/24/15 to ensure resident interventions were up to date. No revisions were necessary at the time of review. 2) Any resident admitted is at risk for the identified deficient practice. An audit was performed by the DON 7/21/15 to ensure an interim care plan is in place and reflective of the residents status for those residents admitted/re-admitted to the facility within the past 30 days with any revisions (if needed) completed by 7/22/15. 3) The DON re-educated licensed nurses regarding the facility standards in the development of an interim care plan and review within 24 hours of admission, fall/ post fall assessment standards (including neuro checks), head injury standard of care, the professional notification/communication to the MD regarding resident change in status, new admit at risk 72hour monitoring standard, completion of a change in status/SBar assessment which was completed 7/22/15.	7/24/15

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F 323	Continued From page 23 the floor of the bathroom lying face down on the floor in his/her own urine with no footwear present. The report noted the resident's statement was he/she woke up and forgot where he/she was, wandered into the bathroom and fell face first. The report noted a right forehead hematoma, however the report lacked evidence of a complete physical assessment after a fall. The nurses progress notes lacked any documentation whatsoever the resident had a fall with a hematoma. The medical record lacked evidence of any post fall documentation. Review of the neurological examination record, dated for 72 hours, was only documented for the 24 hours. The licensed nurses failed to monitor the resident for the additional 2 days; the designated amount of time to assess neurological status. Observation of Resident #161 on 6/24/15 at 8:22 A.M., revealed the resident sat in a chair in his/her room with a hematoma on the right forehead and around the right eye (black eye). During staff interview on 6/22/15 at 4:11 P.M., Licensed Nurse (LN) MM stated the resident fell a few days after admission (6/14/15), with no injury. During an interview with the resident and a family member on 6/24/15 at 8:22 A.M., the resident and family member stated the resident was admitted on Friday, 6/12/15, and fell on Sunday, 6/14/15 at about 3:00 A.M. The resident stated he/she got up to go to bathroom, fell face first and got the black eye. The resident stated, "I don't feel the	F 323	**F323 Continued** 4) The DON/designee will audit the interim care plans for newly admitted residents and if any accident's the post fall assessment standards, professional notification/communication to the physician, and the new admit at risk 72 hour monitoring standard. The audit will also include interviews of licensed staff on how to manage new at risk residents with responses documented during the audit. The DON or designee will audit 3 x per week x 4 weeks, then weekly x 4 weeks, then monthly x 1 month. The DON/designee presents the results of the audit(s) to the QAPI Committee on at least quarterly basis. Any aberrancies are discussed and reviewed by the committee for interventions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445234	A. BUILDING _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 24 same as before my fall; I'm more confused." During interview on 6/24/15 at 10:39 A.M., LN FF stated the resident fell, hit his/her head, got a black eye, and when a resident hit their head, licensed nurses should initiate neurological (neuro) checks for 72 hours to monitor for brain injury. LN FF stated documentation after a fall should include the nurses documenting any resident changes for 72 hours. During interview on 6/24/15 at 11:24 A.M., LN GG stated at admission the nurse completed the Initial Nursing Assessment, then the Registered Nurse (RN) supervisor or Unit Manager initiates a care plan based on the assessment. LN GG stated the resident "was missed", and no care plan was initiated for the resident until Wednesday, 6/17/15. The care plan should have been completed and the care information sent to the CNA kiosk. LN GG stated neurological checks should be done for 72 post fall when a resident hit their head. LN GG stated the resident's neurological status, should have been monitored and documented for 72 hours after a fall, and acknowledged the neurological examination record was not complete. During an interview on 6/24/15 at 11:47 A.M., certified nursing assistant (CNA) HH stated there was not a policy to monitor a new resident more frequently, and they did rounds every 2 hours and assisted as needed for all residents. CNA HH stated he/she cared for the resident on Saturday, 6/13/15, and the resident was not in the Kiosk yet, where they usually get the care information. There were no safety interventions in place; but CNA HH got the resident a walker to use for ambulation in the hall.	F 323		

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F 323	Continued From page 25 During interview on 6/24/15 at 2:09 P.M., LN BB stated there was not a practice in the facility to monitor a newly admitted resident more frequently. Direct care staff should round every 2 hours. During interview on 6/24/15 at 3:54 P.M., LN BB stated he/she expected licensed nurses to complete a physical assessment after a fall and document it in the medical record. LN BB expected licensed nurses to monitor and document a resident's fall, neurological examinations and status of injuries for 72 hours after a fall with a head injury, which was a common standard of nursing practice. LN BB agreed staff failed to complete a physical assessment record in the Fall Incident Report/Investigation. LN BB agreed staff did not record a post fall physical assessment in the progress notes for 72 hours. LN BB stated, "Going by the record I don't know where she got the black eye; it's not documented." The facility provided the policy entitled Falls Standard, dated 11/14, which directed: All new admission will be considered "high risk for falls" and will be assessed and documented on every shift for a minimum of 3 days (72 hours). Review the Nursing Admission Assessment. Complete the Fall Risk Assessment. Review/evaluate other assessments and interdisciplinary assessments. Complete the individual resident care plan. Implement the Interim Plan of Care - Fall Risk Reduction based on individual resident needs. Communicate interventions during shift report and clinical rounds to the care teams as appropriate.	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 26 The facility failed to develop a plan of care to address adequate supervision for Resident #161. The facility failed to monitor and complete neurological examinations for 72 hours after a fall with a hematoma.	F 323		